Family Support & Respite Services

445 E. Dublin Granville Road, Columbus, Ohio 43085 | (tel) 614/844-5847 (fax) 614/844-5916

Application for Approval of Family-Chosen Provider

Please Read and Be Aware: The family certifies by signature that the family assumes responsibility for the health and safety needs of the individual and that the county hoard and FCRS, Inc. shall incur no liability for respite services provided by the identified family-selected respite provider. The family may identify or utilize any person/agency to their liking for family-selected private provider services. By signature, the family acknowledges that reimbursement will be made directly to the family for this provider, in the family name for the family-selected private provider identified. For an agency provider, payment will be made directly to the agency.

NOTE: IF THE FAMILY-SELECTED RESPITE PROVIDER IS A PRIVATE INDIVIDUAL, THEN THE INCLUDED W-9 FORM IS FOR FAMILY USE ONLY (TO BE KEPT BY THE FAMILY). IF THE FAMILY-SELECTED RESPITE PROVIDER IS AN AGENCY OR PRIVATE COMPANY, THE COMPLETED W-9 FORM IS TO BE SENT TO THE FAMILY SUPPORT DEPARTMENT WITH TIDS FORM.

Select by checkmark either a Private Provider or CTE Provider below.
Only one (I) provider and one (I) type of provider per each form.

☐ **Private Respite Provider (PP) OR** ☐ **Counseling, Training, and Education (CTE)**

Only one must be selected by checkmark, either PP or CTE. All information is required on both sides of this form. W-9 forms are required for new CTE providers or new company providers.

Provider Information

(All Applicable Information must be completed)
PLEASE TYPE OR PRINT CLEARLY

Family Name Requesting Provider: _____

Family-Selected Provider Name: _____

If Minor, Parent/Guardian Signature: _____

Provider's Soc. Sec. #: _____

CompanyName: _____

Federal I.D # (required with W-9 form for new providers): _____

Provider's Street Address _____

City, State, Zip: _____

Phone number Work Number: _____

Type of Service Provided: _____

Past Experience in Delivering Service: _____

Certification or Training of Personnel: _____

Provider Hourly or Qtr Hour charge: _____

_____ _____

SIGNATURE OF PROVIDER (REQUIRED) **Date:**

_____ _____

SIGNATURE OF FAMILY REQUESTING PROVIDER (Required) **Date:**

Family certifies that no liability shall be incurred by Franklin County Residential Services, Inc. or the Franklin County Board of MR/DD for services provided by this provider.

For Office Use Only:
Date Received: _____
Approved: _____ Not Approved: _____
Input Date: _____ By: _____

Please Look Over this Form to Ensure:

1. ALL APPLICABLE INFORMATION IS COMPLETED.
2. INCLUDED SIGNATURES REQUIRED.
3. ONLY ONE (1) PRIVATE RESPITE PROVIDER (PP) IDENTIFIED ON THIS FORM BY CHECK MARK ***OR*** ONLY ONE (1) COUNSELING, TRAINING AND EDCUATION PROVIDER (CTE) IDENTIFIED ON THIS FORM BY CHECKMARK.
4. FEDERAL I.D. NUMBERS AND W-9 FORMS ARE SUBMITTED WITH THIS FORM FOR ALL NEW FAMILY-CHOSEN AGENCY PROVIDERS IN THE PRIVATE PROVIDER (PP) AND COUNSELING, TRAINING AND EDUCATION (CTE) CATEGORIES.

SEND THIS TWO-SIDED PAGE TO FAMILY SUPPORT & RESPITE SERVICES, 445 E. DUBLIN GRANVILLE ROAD, WORTHINGTON, 43085 FOR FAMILY-CHOSEN APPROVAL OF PROVIDERS. ALL APPLICABLE INFORMATION MUST BE COMPLETE.